PCC Consent for Counseling Services

Today's Date________________________

Client First Name:__________________________________**MI:**_______**Last Name:**____________________________________

Client Date of Birth:________________________**Social Security #:**_____________________**Gender:**_________________________

Ethnicity:________________________________**Marital Status**____

Client Driver's License #:____**State Issued:**_______________________________

Client Address:___________________________________**City**_____________________**State**______**Zip Code**_______________

Home Phone #:______________________**Cell Phone #:**_________________________**Work #:**______________________________

Email:____**Ok to leave message?** ____**Y** ____**N**

Preferred Contact Method for Appointment Reminders: ____**Electronic Text** ____**Email** ____**Telephone Msg**

Legal Guardian (skip if not applicable):

_____**Check if Client is a Minor** **Legal Custody:** ______**Mother** _____**Father** **Joint** __**Other**

Note: If minor, parent / legal guardian(s) must provide PCC copies of the following legal documents if separated, divorced, or legal guardianship:

- Terms of Legal Separation
- Temporary and/or Final Custody & Divorce Decree
- Legal Guardianship

Important Note: *If parent / guardian of minor client is unable to provide PCC copies of legal documentation at time of intake, by signing* ***PCC Consent for Counseling Services consent form****, presenting parent / guardian herby acknowledges you have legal authority to make medical & mental health decisions on behalf of child and further confirms you take financial responsibility for child's treatment independent of any other parent or party's consent.*

______**Presenting Parent / Guardian Initials**

Emergency Contact List / Family Members involved in Client's Treatment

Emergency Contact Name:____**Relationship:**_____________________________________

Emergency Contact Address:__________________________________**City**___________________**State**______**Zip**_____________

Emergency Contact Phone #:__________________________________**Email**____

Emergency Contact List / Family Members involved in Client's Treatment

Emergency Contact Name:_______________________________ **Relationship:** _______________________

Emergency Contact Address:_____________________________ **City**_______________ **State**______ **Zip**__________

Emergency Contact Phone #: ____________________________ **Email**_____________________________

Insurance Policy Holder / Financially Responsible Person Information

[Please Bring Your Insurance Card and Co-pay Fees to Your Appointment]

PRIMARY INSURANCE

First Name:_____________________________ **MI:**________ **Last Name**:___________________________

Date of Birth:__________________________ **Social Security #**:_________________________________

Address:______________________________________ **City**:_____________________________

State:____ **Zip code**:________ **Phone #**:________________ **Email:**_________________________

Policy Holder's Employer:____________________________ **Primary Insurance Plan Name**:_______________

Insurance ID #:____ **Insurance Group Policy#**:______________

SECONDARY INSURANCE (SKIP IF NOT APPLICABLE)

First Name:_____________________________ **MI:**________ **Last Name**:___________________________

Date of Birth:__________________________ **Social Security #**:_________________________________

Address:______________________________________ **City**:_____________________________

State:____ **Zip code**:________ **Phone #**:________________ **Email:**_________________________

Policy Holder's Employer:____________________ **Primary Insurance Plan Name**:__________________________

Insurance ID #:___________________________________ **Insurance Group Policy#**:______________________

PALMETTO
COUNSELING & CONSULTING

I understand that I am financially responsible for all deductibles, co-pays and missed appointments, or appointments cancelled without 48-hour advanced notice. I confirm that information I provided is accurate and complete, to the best of my knowledge.
I understand that if I do not inform Palmetto Counseling & Consulting Services, LLC of changes in my insurance coverage before services are rendered, I will be financially responsible for payment in full. I am also responsible for informing Palmetto Counseling & Consulting Services, LLC of any changes in my address, phone number, and emergency contact information.

YOU WILL BE RESPONSIBLE TO FIND A NEW PROVIDER IF YOU FAIL TO SHOW UP FOR TWO CONSECUTIVE APPOINTMENTS WITHOUT PROVIDING 48-HOUR ADVANCED NOTICE.

Assignment of Benefits

I hereby assign, transfer. and set over to Palmetto all my rights, title, and interest to my medical reimbursement benefits under my insurance policy and authorize Palmetto to file (and assign to Palmetto my right to file) my insurance claim under my policy for Palmetto's services. I further authorize the release of any medical information needed to determine benefits, including psychiatric, substance abuse (drug or alcohol), psychological, assessment, diagnosis, and treatment information for the routine processing of these claims.

This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not release me of my obligation to pay such bills if not paid by my Insurance Company or of any balance due after payments by my Insurance Company.

By my signature, I am consenting to treatment at Palmetto Counseling, and I acknowledge that I have read, understand, and agree to the policies and procedures of counseling services as defined in the PCC Intake Packet I have received.

____

Client Name [Please Print]

____

Client Signature Date

____

Parent / Legal Guardian Signature [If applicable] Date